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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **PETER JOHN DEJANOVICH** **8301 Dandelion Drive** **Elk Grove, California 95624** **Registered Nurse License No. 609871** Respondent.	Case No. 2010-555 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about November 25, 2002, the Board issued Registered Nurse License Number 609871 to Peter John Dejanovich ("Respondent"). Respondent's registered nurse license expired on June 30, 2008.

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct . . .

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
>
> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Health and Safety Code section 11173, subdivision (a), states, in pertinent part, that "[n]o person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . ."

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of

the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AT ISSUE

9. "Demerol", a brand of meperidine hydrochloride, a derivative of pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(17).

10. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

11. "Dilaudid", a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

MERCY SAN JUAN MEDICAL CENTER

FIRST CAUSE FOR DISCIPLINE

(Diversion of Controlled Substances)

12. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that on or about July 1, 2006, and July 2, 2006, while on duty as a registered nurse in the Emergency Department at Mercy San Juan Medical Center (hereinafter "medical center"), Carmichael, California, Respondent obtained the controlled substances Demerol, morphine, and Dilaudid by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: On July 1, 2006, and July 2, 2006, Respondent removed various doses of Demerol, morphine, and Dilaudid from the medical center's Omnicell system (a computerized medication dispensing system; hereinafter "Omnicell") for patients B and D when there were no physicians' orders authorizing the medications for the patients. Further, Respondent failed to chart the administration of the controlled substances on the patients' Medication and Treatment Records or document the wastage of the controlled substances in the Omnicell. After discovering that the narcotics had been removed without physicians' orders, medical center staff confronted Respondent and requested that he participate in a drug screening. Respondent refused to submit to a drug test and fled the scene.

SECOND CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that on or about July 1, 2006, and July 2, 2006, while on duty as a registered nurse in the Emergency Department at Mercy San Juan Medical Center, Carmichael, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances Demerol, morphine, and Dilaudid, as follows:

Patient B:

a. On July 1, 2006, at 09:38:11 hours, Respondent removed a total of 50 mg of Demerol from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Demerol on the patient's Medication and Treatment Record ("MTR"), document the wastage of the Demerol in the Omnicell, and otherwise account for the disposition of the Demerol 50 mg.

b. On July 1, 2006, at 10:53:25 hours, Respondent removed morphine 4 mg from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the morphine on the patient's MTR, document the wastage of the morphine in the Omnicell, and otherwise account for the disposition of the morphine 4 mg.

c. On July 2, 2006, at 1:08:53 hours, Respondent removed Dilaudid 2 mg from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's MTR, document the wastage of the Dilaudid in the Omnicell, and otherwise account for the disposition of the Dilaudid 2 mg.

Patient D:

d. On July 1, 2006, at 09:38 hours, Respondent removed a total of 50 mg of Demerol from the Omnicell for the patient when, in fact, there was no physician's order authorizing the

medication for the patient. Further, Respondent failed to chart the administration of the Demerol on the patient's MTR, document the wastage of the Demerol in the Omnicell, and otherwise account for the disposition of the Demerol 50 mg.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

14. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that on or about July 2, 2006, while on duty as a registered nurse in the Emergency Department at Mercy San Juan Medical Center, Carmichael, California, Respondent committed an act constituting unprofessional conduct, as follows: Respondent refused to submit to a drug screen or test as requested by medical center staff when it was discovered that he had removed the controlled substances Demerol, morphine, and Dilaudid from the Omnicell without physicians' orders, as set forth in paragraphs 12-13 above.

FOURTH CAUSE FOR DISCIPLINE

(Use of Controlled Substances/Alcohol in a Dangerous Manner)

15. Respondent has subjected his license to discipline pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (b), in that on or about July 2, 2006, while employed at Mercy San Juan Medical Center, Respondent used controlled substances/alcohol to an extent or in a manner dangerous to himself or others or to the extent that such use impaired his ability to conduct with safety to the public the practice authorized by his license, as follows:

a. Respondent was observed staring at a board for 5 minutes with one arm raised up. Respondent then sat down and appeared comatose and unaware of any activity around him. Respondent was confronted about his strange activity by medical center staff and asked to submit a urine test. Respondent refused, claimed an emergency and left the hospital, abandoning his patients' care. He returned several hours later stating that he had tried to kill himself and had stabbed himself with a knife. Staff observed numerous needles, syringes and a bloodied knife in the front passenger seat of Respondent's car. There was also an opened alcoholic beverage bottle

in the front cabin of the car. Respondent admitted to a staff member that he had been doing drugs for over a month.

KAISER OAKLAND MEDICAL CENTER

FIFTH CAUSE FOR DISCIPLINE

(Diversion of Controlled Substances)

16. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that on or about July 27, 2007, while on duty as a registered nurse in the Emergency Department at Kaiser Oakland Medical Center (hereinafter "Kaiser"), Oakland, California, Respondent obtained the controlled substances morphine and Dilaudid by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: On July 27, 2007, Respondent removed various doses of morphine and Dilaudid from Kaiser's Pyxis system (a computerized medication dispensing system; hereinafter "Pyxis") for patient 1. In fact, there was not a physician's order authorizing the Dilaudid for the patient. Further, the quantities of morphine removed from the Pyxis were in excess of the doses ordered by the patient's physician. Additionally, Respondent failed to chart the administration of either controlled substance on the patient's Medication Administration Record ("MAR") or document the wastage of the controlled substances in the Pyxis.

SIXTH CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

17. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that on or about July 27, 2007, while on duty as a registered nurse in the Emergency Department at Kaiser Oakland Medical Center, Oakland, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances morphine and Dilaudid, as follows:

a. On July 27, 2007, at approximately 2015 hours, Patient 1's physician ordered morphine 6 mg to be administered to the patient by IV every 2 hours as needed.

b. On July 27, 2007, at 19:45 hours, Respondent removed morphine 4 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing the medication for the patient at that time. Further, Respondent failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the Pyxis, and otherwise account for the disposition of the morphine 4 mg.

c. On July 27, 2007, at 20:13 hours, Respondent removed morphine 10 mg from the Pyxis for the patient when, in fact, the physician's order called for the administration of only 6 mg of morphine for the patient. Further, Respondent charted on the patient's MAR that he administered morphine 6 mg to the patient at 20:15 hours, but failed to document the wastage of the remaining 4 mg of morphine in the Pyxis and otherwise account for the disposition of the morphine 4 mg.

d. On July 27, 2007, at 21:04 hours, Respondent removed morphine 10 mg from the Pyxis for the patient when, in fact, the physician's order called for the administration of only 6 mg of morphine for the patient, and the next dose of morphine was not due to be administered to the patient until approximately 22:15 hours. Further, Respondent failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the Pyxis, and otherwise account for the disposition of the morphine 10 mg.

e. On July 27, 2007, at 21:57 hours, Respondent removed morphine 10 mg from the Pyxis for the patient when, in fact, the physician's order called for the administration of only 6 mg of morphine for the patient, and the next dose of morphine was not due to be administered to the patient until approximately 22:15 hours. Further, Respondent failed to chart the administration of the morphine on the patient's MAR, document the wastage of the morphine in the Pyxis, and otherwise account for the disposition of the morphine 10 mg.

f. On July 27, 2007, at 22:11 hours, Respondent removed Dilaudid 8 mg from the Pyxis for the patient when, in fact, there was no physician's order authorizing this medication for the patient. Further, Respondent failed to chart the administration of the Dilaudid on the patient's

MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 8 mg.

g. On July 27, 2007, at 22:24 hours, Respondent removed morphine 50 mg from the Pyxis for the patient when, in fact, the physician's order called for the administration of only 6 mg of morphine for the patient. Further, Respondent charted on the patient's MAR that he administered morphine 6 mg to the patient at 22:16 hours, but failed to document the wastage of the remaining 44 mg of morphine in the Pyxis and otherwise account for the disposition of the morphine 44 mg.

SEVENTH CAUSE FOR DISCIPLINE

(Use of Controlled Substances in a Dangerous Manner)

18. Respondent has subjected his license to discipline pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (b), in that on or about July 27, 2007, while employed at Kaiser, Respondent used controlled substances to an extent or in a manner dangerous to himself or others or to the extent that such use impaired his ability to conduct with safety to the public the practice authorized by his license, as follows:

a. Respondent was confronted by Kaiser staff regarding his withdrawals of Morphine. Respondent claimed to have an emergency and left the hospital in the middle of his shift, abandoning the patients in his care. Respondent called the hospital an hour later and stated that he "was tired of having this problem," that he "didn't want his life to end like this," and that he was planning to hurt himself.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 609871, issued to Peter John Dejanovich;

2. Ordering Peter John Dejanovich to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 4/26/10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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